Treatment of Uterine Retrodisplacements By Vagino Fixation,

With Reports of Cases.

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TREATMENT OF UTERINE RETRODISPLACEMENTS, BY VAGINO FIXATION. WITH REPORTS OF CASES.

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THERE are numerous cases of uterine retrodisplacements giving rise to symptoms which for various reasons are not amenable to the ordinary routine treatment of massage, followed by the application of the tampon or pessary, and for these several operative procedures have been devised. The principal ones are, that known as the Alexander operation whose chief champions in this country are Cleveland and Munde; suspensio uteri, brought forward largely by Howard Kelly, of Baltimore, and that of Mackenrodt, of Berlin, in this country advocated and described by Vineberg, *New York Medical Journal* of Oct. 27, 1894.

To this latter operation it is the purpose of this paper to particularly call attention. The simplicity of its technique, the safety, ease and rapidity with which it can be performed, and the good results obtained, make it, in the writer's opinion, a formidable rival of the other methods mentioned for the relief of the class of cases under consideration. The technique described will be that employed in the cases about to be narrated. The patient is prepared as for

a vaginal hysterectomy and is placed on the table in the dorsal position with the thighs flexed and held in place by a clover crutch. As in this class of cases there is more or less endometritis, it is well to begin the operation by curetting the uterus with a sharp curette, gauze not being placed in the cavity. Any existing laceration of the cervix should be repaired, sutures of catgut being used. These steps having been taken, the cervix is grasped and drawn downward and forward by the aid of a pair of bullet forceps. Then a portion of the anterior vaginal wall about three-quarters of an inch below the meatus urinarius is taken up in the same way and drawn forward and upward, thus stretching the wall. An incision is made beginning at the last named point and continuing to the cervix. If this wall is more or less prolapsed, the incision, instead of being straight, should be oval, allowing for the removal of sufficient tissue to overcome this defect when the sutures which close the vaginal wound are placed. These flaps are dissected from the inferior surface of the bladder into which a sound is passed and by its aid the thickness of the bladder wall is estimated and its lower border defined. A needle threaded with pedicle silk is passed through the inferior edge of either flap and tied, the ends being kept long. These serve as retractors and the flaps being held aside, a curved transverse incision is made at the cervico-vesical junction. The bladder is freely separated from the uterus by blunt dissection with the finger, the vesico uterine fold of peritoneum being divided by the aid of scissors. The patient's hips are elevated which allows the bladder and intestines to gravitate from the uterus, the fundus of which is brought into view and is seized by a pair of bullet forceps and drawn forward. The ovaries and tubes are inspected after any existing adhesions

have been broken up and if diseased are removed. A suture of pedicle silk (No. 12) is passed by means of a curved Hagadorn needle through the left vaginal flap at a point slightly distant from its superior margin, then through the muscular tissue of the anterior uterine wall close to the fundus and then through the right vaginal flap near its upper margin. A second suture of silkworm gut is passed in the same way about one-third of an inch below the first. The uterus being well antiverted, the first suture is tied loosely in the ordinary way and the second is passed through an opening in a small lead shield and is fastened by a perforated shot, which is closed by pinching it with a pair of artery clamps. The balance of the wound in the anterior vaginal wall, after free irrigation with saline solution and the application of hydrogen dioxide if there is much oozing, is closed by means of interrupted sutures of horse hair and the wound is sealed by painting it over with a 10% solution of iodoform in ether. A small quantity of gauze is placed in the vagina for the purpose of effecting drainage, and an antiseptic pad is applied to the vulva. The time occupied by the operation is usually twenty minutes. The patient's urine is drawn by the aid of a new catheter which should preferably be a short one of glass to which is attached a rubber tube till it can be voided voluntarily, which is generally at the end of the third day. The vaginal gauze is removed about this time and is not replaced. A daily douche of a weak bichloride solution is given, after which the iodoform solution is again painted over the wound. The vaginal sutures are removed at the end of a week or sooner if they begin to cut the tissues. The sutures which hold the uterus in place are allowed to remain for as long a time as is possible. The patient is retained in the horizontal position for two

weeks and is then allowed to assume a sitting posture and at the end of the third or fourth week is permitted to leave the bed and move about.

Case 1. Oophorectomy and Vaginal Fixation.—C. R., a single woman, aged 20 years, was admitted to the uterine ward of the New York City Hospital on Oct. 27, 1894. She stated that her first menstrual period occurred during her sixteenth year, that it had been somewhat painful but regular and of the monthly type. She had never been pregnant. For the past eighteen months she had had constant pain in her back. She had recently suffered from vaginitis and since this attack her menstrual periods had been accompanied by severe pain. A bimanual vaginal examination revealed an enlarged tender, and retroplaced uterus also bilateral enlargement and tenderness of the tubes and ovaries. On November 7, after proper preparation, the patient having been placed under ether anæsthesia, the uterus was drawn forward and after dilatation of the cervix its cavity was curetted and irrigated. The anterior vaginal wall was incised, the bladder separated and the uterus antiverted as previously described. Both ovaries were found to be somewhat adherent and cystic and were removed. The pelvic cavity was flushed with hot saline solution and the uterus was attached to the anterior vaginal wall and the vaginal wound closed, drainage not being employed. The paitent's convalescence was uneventful. Her highest bodily temperature 100.4° F., occurring on the second day the highest pulse rate was 90, and her respirations 24, all becoming normal on the third day and remaining so. The patient was catheterized till the evening of the second day when she voided her urine voluntarily. The wound healed primarily. On the twenty-ninth day the uterine sutures were removed. The uterus

was found to be anterior. The patient had had no pain or bladder symptoms.

Case II. Vagino-Fixation.— B A., a widow thirty-four years of age was admitted to the uterine ward of the New York City Hospital on September 4, 1894. She stated that her first menstrual period occurred during her sixteenth year, and that it has been painless, regular and of the monthly type; she had had no miscarriages. One year ago she had given birth to a child. About nine months later menstruation had become irregular and painful and of late she had had a constant pain in her back and left side. A vaginal examination revealed a retroplaced and tender uterus.

As it was evident that the patient was suffering from endometritis, an operation was advised, consented to and was performed on Nov. 27, 1894. The uterus, after curettage and irrigation of its cavity and the usual incision of the vaginal wall, was anteverted and its fundus attached to the wall. The patient's convalescence was uneventful. She voided her urine naturally on the third day. Her highest bodily temperature was 99.4, her pulse ranging from 80 to 97. On December 4, it was noted that the vaginal wound had healed primarily, that the patient had complained of no pain or bladder symptoms. On the thirty-first day the deep sutures were removed and the uterus was forward and in good position. The following day the patient was allowed to leave the bed. Her menstruation recurred on January 1, lasting four days and was almost free from pain.

Case III. Trachelorrhaphy, Oophorectomy and Vagino Fixation.—H. D., a single woman, was admitted to the uterine ward of the New York City Hospital on November 16, 1895. She stated that her first menstrual period had occurred during her nin-

teenth year and that it had been somewhat irregular. She had been costive. She had recently been confined, since which time she had had a constant dull pain in her side and back radiating into her lower extremities. On making abdominable pressure a localized tenderness was found to exist in the right inguinal region. Vaginal examination revealed an enlarged retroplaced and tender uterus with a cervical laceration on its right side, also an enlarged and tender tube and ovary on the same side. The operation was performed on the twenty-fourth of January and consisted of a trachelorrhaphy, Curettage followed by the incision of the anterior vaginal wall, antiversion of the uterus, the removal of the right tube and ovary and the fixation of the fundus to the anterior vaginal wall. The patient's highest bodily temperature following the operation was 100° F., on the day following that on which the operation took place and became normal on the afternoon of the succeeding day. The patient voided her urine normally on the fourth day. The patient complained of no pain or bladder symptoms.

Case iv. Amputation of the Cervix and Vagino Fixation.—T. P., a single woman, was admitted into the uterine ward of the New York City Hospital on December 10, 1894. She stated that her first menstrual period occurred during her fifteenth year, that it had been regular and of the monthly type, but accompanied by severe pain. She had given birth to one child seven years previously. About three months prior to her admission she had had an instrumental abortion performed. This had given rise to a severe pelvic pain which was accompanied by a bloody vaginal discharge. A bimanual vaginal examination revealed an enlarged and tender uterus with an hypertrophied cervix. An operation was advised and

was performed on December 11, and consisted of curettage, amputation of the cervix and fixation of the uterine fundus to the anterior vaginal wall. The patient's highest bodily temperature 100.2° F., was on the day following that on which the operation was performed. The patient passed her urine voluntarily on the fourth day. The vaginal wound healed primarily. There were no bladder symptoms. On the 38th day the uterine sutures were removed and the patient was allowed to sit up. On January 30 it was noted that the patient had had no pain or bladder symptoms, that the uterus was anterior and that her menstruation following the operation, while rather profuse had been painless.

The notes of several other cases in which similar operations were performed during the writer's term of service at the hospital, October, 1894, to February, 1895, have unfortunately been lost but their stories were of the same tenor as the foregoing. In the latter part of March, my colleague Dr. Pryor wrote me that he had examined all of these cases and that the immediate results were excellent. "It is unfortunate that these patients could not have been observed for a longer period of time but it has been shown that this operation is not one difficult of performance, that it permits of the examination of the uterus and its adnexa and their removal even if somewhat adherent. If, however, bilateral disease of these organs exists, the writer's experience leads him to believe that instead of fixation of the uterus following their removal a hysterectomy should be performed. That vagino fixation is followed by little constitutional disturbance and no danger to life, so far there having been no fatal cases recorded; that it can be quickly performed; that it places the uterus in good position; that it is not usually followed by pain or

bladder symptoms; that it leaves no scar or liability to hernia and that it lessens the danger of intestinal adhesions. Others have found that the uterus placed anteriorally by this operation remained in good position even after pregnancy and delivery at full term.

While more time must elapse before we can pass final judgment on the value of this procedure, the writer believes that it will eventually be recognized as the proper means of treatment for many cases of uterine retrodisplacements which give rise to symptoms.

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